

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

647

CERTIFICATE OF DEATH

00639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 10 Minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	
3. NAME OF DECEASED (Type or print) Baby		First Middle Girl	4. DATE OF DEATH Ahern January 13, 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH -----		9. AGE (In years (last birthday) yrs. Months Days Hours Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Roy Jean Ahern		14. MOTHER'S MAIDEN NAME Hazel Marie Pifer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT "Mother" Hazel Marie Ahern, Oakland, Md.		Address Rt. #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 mos gestat. - 16 mo. etc.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13, 1959, to 1-13, 1959, that I last saw the deceased alive on 19, and that death occurred at 6:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>James H. Feaster Jr., M.D.</i> 58-1-54 Oakland, Md. 1-17-59			
PHYSICIAN'S NAME (Type) James H. Feaster Jr., M.D.		22d. LOCATION (City, town, or county) near Mt. Lake Park, Md. (State)	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/14/1959		22c. NAME OF CEMETERY OR CREMATORY John Our Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>		24a. REC'D BY REGISTRAR ADDRESS Oakland, Md. DATE JAN 19 59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Paine</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG237 1-20-59 et

648 CERTIFICATE OF DEATH

00640

Reg. Dist. No.....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
Garrett. Friendsville, Md.		70 yrs		Maryland Garrett.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) OF DEATH		
(First) Harry (Middle) J. (Last) Black.			Jan 6th 1959		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1871 Jan 28, 1872	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY B & O Agent.	11. BIRTHPLACE (State or foreign country) Somerfield, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert G. Black.			14. MOTHER'S MAIDEN NAME Susan Brownfield.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.			16. SOCIAL SECURITY NO. 705-03-9930-1		
17. INFORMANT & ADDRESS Margaretha Bechley Friendsville, Md.			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) Aging			INTERVAL BETWEEN ONSET AND DEATH		
Generalized Arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Parkinson's Disease					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 19.58 to 1-6-1959	
22. I hereby certify that I attended the deceased from 9-20-58 to 1-6-1959, that I last saw the deceased alive on 1-6-1959, and that death occurred at 8 A.M. from the causes and on the date stated above. SIGNATURE Pedro Lina M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1-9-59		NAME OF CEMETERY OR CREMATORIAL ADDISON CEMETERY	
24. REC'D BY REGISTRAR JAN 14 '59		REGISTRAR'S SIGNATURE Arthur S. H.		LOCATION (City, town, or county) ADDISON, PA.	
DATE				25. FUNERAL DIRECTOR'S SIGNATURE H. B. Riehlebarger, Addison, Pa.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

649

CERTIFICATE OF DEATH

Reg. Dist. No.

00649

1. PLACE OF DEATH a. COUNTY Barrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Terra Alta 85X-3	
3. NAME OF DECEASED (Type or print) First Virginia Middle Frances Last Bohon		d. STREET ADDRESS 216 Aurora Avenue	
4. DATE OF DEATH January 27th		Month	Year 1959
5. SEX Female Caucasian		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1870	
9. AGE (In years from last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 23 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. George, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Taylor White		14. MOTHER'S MAIDEN NAME Elizabeth Jane Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Pauline Fitzer, Terra Alta, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN DUE TO <u>6 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>443X</u>			
b) <u>Hypertensive Cardiovascular</u> DUE TO <u>15 yrs</u> c) <u>Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 12, 1958</u> to <u>Jan. 7, 1959</u> , that I last saw the deceased alive on <u>Jan. 8, 1959</u> , and that death occurred at <u>8:25 A M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>William Harriman</u> M.D. Terra Alta, W. Va. DATE SIGNED Jan. 28, 1959			
PHYSICIAN'S NAME (Type) WILLIAM HARRIMAN M. D.			
22a. BURIAL, CREMATION, REMOVAL & BURIAL 1/29/59		22b. DATE THEREOF 1/29/59	
22c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. Watson</u> , Terra Alta, W. Va.		ADDRESS	
24a. REC'D BY REGISTRAR JAN 29 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harriman</u>	
Md. F.D. License No. A 6834			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CABLE TO STADITZ

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	80337	80338	80339	80340	80341	80342	80343	80344	80345	80346	80347	80348	80349	80350	80351	80352	80353	80354	80355	80356	80357	80358	80359	80360	80361	80362	80363	80364	80365	80366	80367	80368	80369	80370	80371	80372	80373	80374	80375	80376	80377	80378	80379	80380	80381	80382	80383	80384	80385	80386	80387	80388	80389	80390	80391	80392	80393	80394	80395	80396	80397	80398	80399	80400	80401	80402	80403	80404	80405	80406	80407	80408	80409	80410	80411	80412	80413	80414	80415	80416	80417	80418	80419	80420	80421	80422	80423	80424	80425	80426	80427	80428	80429	80430	80431	80432	80433	80434	80435	80436	80437	80438	80439	80440	80441	80442	80443	80444	80445	80446	80447	80448	80449	80450	80451	80452	80453	80454	80455	80456	80457	80458	80459	80460	80461	80462	80463	80464	80465	80466	80467	80468	80469	80470	80471	80472	80473	80474	80475	80476	80477	80478	80479	80480	80481	80482	80483	80484	80485	80486	80487	80488	80489	80490	80491	80492	80493	80494	80495	80496	80497	80498	80499	80500	80501	80502	80503	80504	80505	80506	80507	80508	80509	80510	80511	80512	80513	80514	80515	80516	80517	80518	80519	80520	80521	80522	80523	80524	80525	80526	80527	80528	80529	80530	80531	80532	80533	80534	80535	80536	80537	80538	80539	80540	80541	80542	80543	80544	80545	80546	80547	80548	80549	80550	80551	80552	80553	80554	80555	80556	80557	80558	80559	80560	80561	80562	80563	80564	80565	80566	80567	80568	80569	80570	80571	80572	80573	80574	80575	80576	80577	80578	80579	80580	80581	80582	80583	80584	80585	80586	80587	80588	80589	80590	80591	80592	80593	80594	80595	80596	80597	80598	80599	80600	80601	80602	80603	80604	80605	80606	80607	80608	8060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

650

CERTIFICATE OF DEATH

Reg. Dist. No.

00642

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jennings		c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Jennings		
3. NAME OF DECEASED (Type or print) H. arry		First Nelson	Middle Broadwater	
4. DATE OF DEATH	Month January	Day 18	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899 March 27, 1899	
9. AGE (In years lost birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. KIND OF BUSINESS OR INDUSTRY Self employed	12. BIRTHPLACE (State or foreign country) Avilton, Md.	
13. FATHER'S NAME Lloyd F. Broadwater	14. MOTHER'S MAIDEN NAME Lucinda Ross	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 216-10-5383		17. INFORMANT Mrs. Vespa Broadwater, Jennings, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Acute myocardial infarction 10 hrs. Coronary insufficiency ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		Jan. 18, 1959, to Jan. 18, 1959, that I last saw the deceased alive on Jan. 18, 1959, and that death occurred at 6:00 P.M., from the causes and on the date stated above.		
ACTUAL SIGNATURE A. Paige Strong		ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED 1/21/59		
PHYSICIAN'S NAME (Type) A. Paige Strong, M.D.		Grantsville, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/21/59	22c. NAME OF CEMETERY OR CREMATORIY Grantsville	22d. LOCATION (City, town, or county) (State) Grantsville, Garrett, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Dorothy Newman	ADDRESS Grantsville, Md.	24a. REC'D BY REGISTRAR DATE JAN 22 '59	24b. REGISTRAR'S SIGNATURE Arling S. Kraus	

CERTIFICATE OF DATA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00643

Reg. Dist. No.

651

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Garrett		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Garrett	
Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
6 hours		X Oakland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		STREET ADDRESS	
Garrett County Memorial Hospital		115 Oak Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
		Grace	Brown
4. DATE OF DEATH		Month	Day
		January	29
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
		54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Own Home	Maryland
12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Beckman		Lilly Walters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT
		Address	
		Charles L. Brown, 115 Oak St. Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, Crushed chest		11 hours	
IMMEDIATE CAUSE (a) 816X DUE TO Cerebral concussion		11 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		11 hours	
DUE TO Compound fracture right leg.		11 hours	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		Head on auto collision near Oakland, Md. 6:15 P.M. 1-28-59	
20c. TIME OF INJURY Month Day Year Hour 1-28-59 6:15 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, doctor's office, etc.) Road Rt. 39	
		20f. (City or town) Garrett, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. James H. Feaster, Jr.		DATE SIGNED 1-29-59	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (ACTING) 1-29-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/1959	
		22c. NAME OF CEMETERY OR CREMATORIUM Thayerville Cemetery	
		22d. LOCATION (City, town, or county) Garrett Co., Maryland. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		24a. REC'D BY REGISTRAR FEB 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RE: ADDITIONAL INFORMATION REQUESTED BY THE
PLAINTIFFS TO ESTABLISH THE VIABILITY OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film 1-2-100-27
CERTIFICATE OF DEATH

652

Reg. Dist. No. 00644

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND Bloomington	
3. NAME OF GRACE (Type or print)		First GRACE	Middle
4. DATE OF DEATH JANUARY 15 1959		Month JANUARY	Day 15
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/74
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Grafton, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Blue	
14. MOTHER'S MAIDEN NAME Don't Know		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	
16. SOCIAL SECURITY NO. 		17. INFORMANT SUSAN PATTISON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident		INTERVAL BETWEEN ONSET AND DEATH 	
DIX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Atherosclerosis			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 6:33 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard F. Leighton M.D. Jan. 17 1959			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) RICHARD F. LEIGHTON, M.D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19/59	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Thorne		24a. REC'D BY REGISTRAR JAN 20 '59	24b. REGISTRAR'S SIGNATURE J. S. Thorne
ADDRESS Piedmont, W.Va.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00645

CERTIFICATE OF DEATH

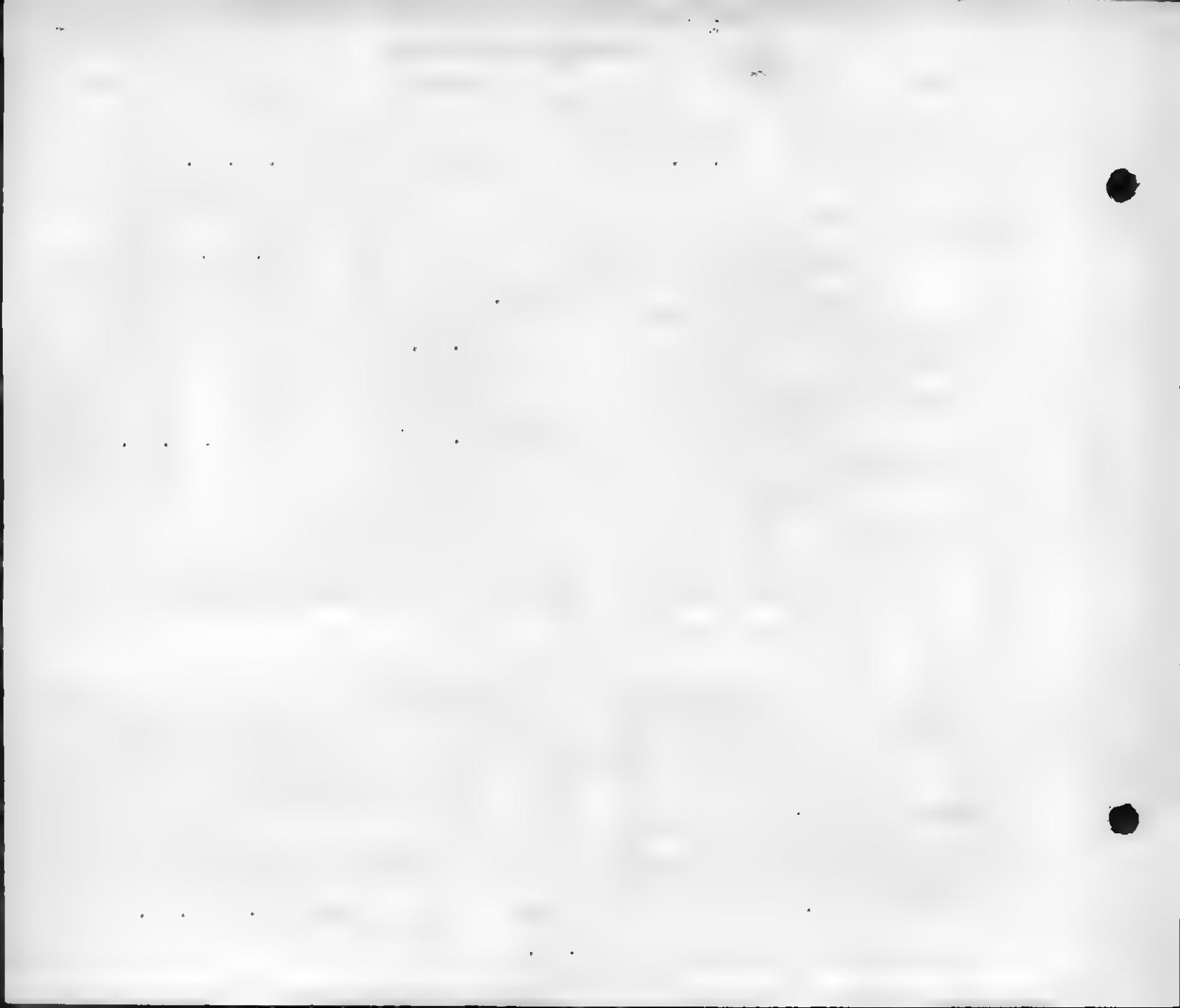
Reg. Dist. No.

653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormanian, W.Va.		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormanian, W.Va.		e. STREET ADDRESS	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franklin James Childs		First Middle Last	4. DATE OF DEATH Jan. 15, 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) W.Va.	9. AGE (In years last birthday) 87 yrs.
13. FATHER'S NAME Jessie Childs		14. MOTHER'S MAIDEN NAME Sarah Feathers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT James L. Childs Gormanian, W.Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dystrophy</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 44d x (b) <i>Cardio-Vascular - Renal Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fever - Scrotal hernia (bilateral)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 While <input type="checkbox"/> Not while p. m. <input type="checkbox"/> at work <input type="checkbox"/>	
21. I certify that I attended the deceased from <i>Jan. 13, 1959</i> to <i>Jan. 15, 1959</i> , that I last saw the deceased alive on <i>Jan. 13, 1959</i> , and that death occurred at <i>1527 M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Hagerstown, Md</i> DATE SIGNED <i>Jan. 17-59</i>	
ACTUAL SIGNATURE <i>Ralph Colandella</i>		22d. LOCATION (City, town, or county) <i>Gormanian, W.Va.</i>	
PHYSICIAN'S NAME (Type) <i>Ralph CAHAN DREW</i>		(State) <i>W.Va.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF Jan. 17, 1959	
22g. NAME OF CEMETERY OR CREMATORIAL Fairview		22h. LOCATION (City, town, or county) <i>Gormanian, W.Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne C. Spiggle</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 13 59</i>	
ADDRESS <i>Davis, W.Va.</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Trahan</i>	



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

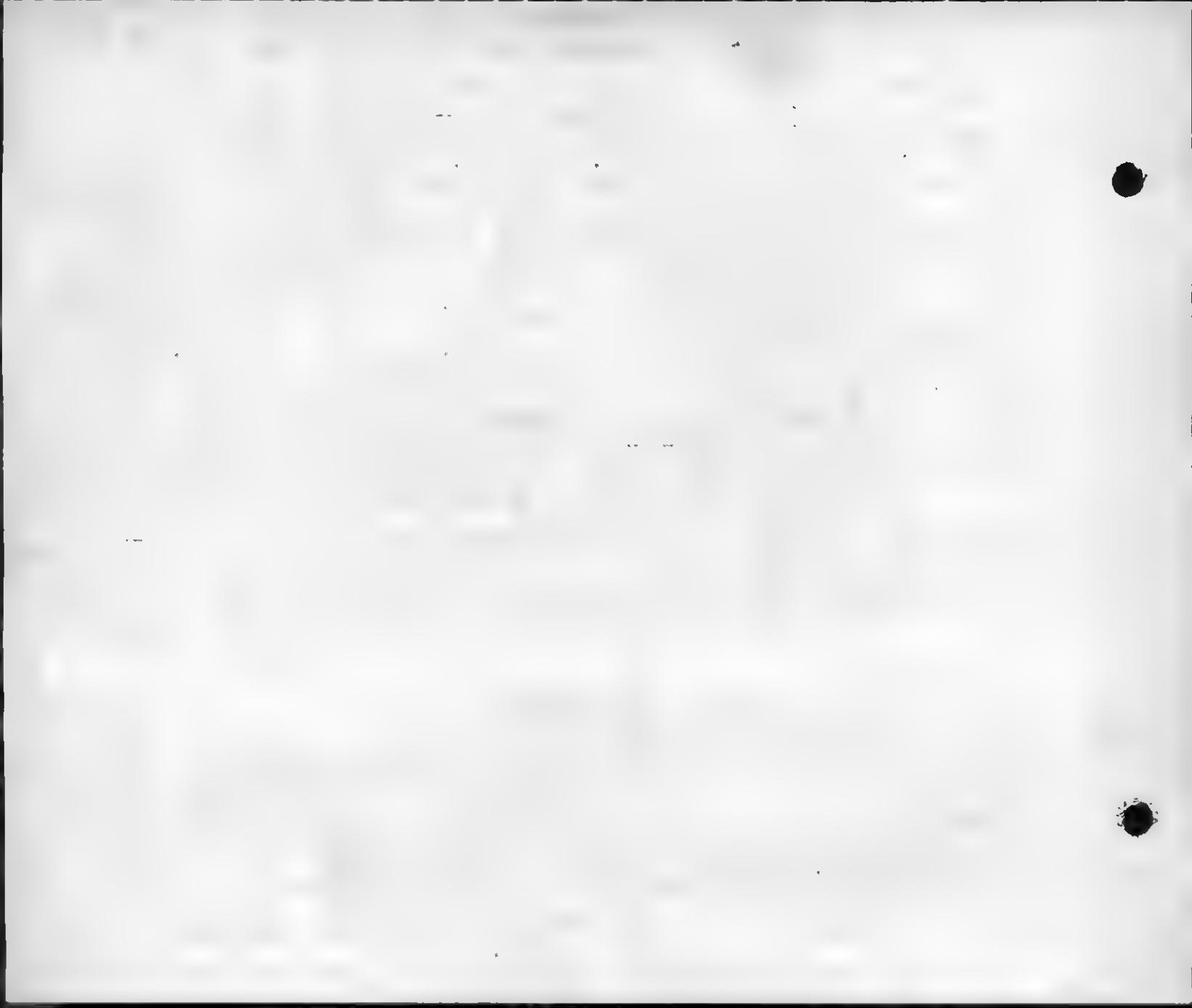
00646

Reg. Dist. No.

654

TO MEDIICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN lb 30 Min.		d. STATE Md. Penn b. COUNTY Bedford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 3 Bedford		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George		First Washington	Middle Cover	4. DATE OF DEATH Jan 26 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1905	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 14 YEARS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Cover		14. MOTHER'S MAIDEN NAME Bertha Boal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-20-6513		17. INFORMANT Address Stanley Cover-Bedford, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis, Left DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM MEDICAL DISEASE CONDITION GIVEN IN PART I(a)					
20c. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE JAMES H. FEASTER, JR. MD (ACTING)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 1-26-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF Jan. 26, 1959	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Westernport, Md.		22d. LOCATION (City, town, or county) (State) Bedford, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE El. B. Hall		24a. REC'D BY REGISTRAR DATE 1-28-59		24b. REGISTRAR'S SIGNATURE C. L. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

655 CERTIFICATE OF DEATH

Reg. Dist. No. **00647**

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 2 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home		d. STREET ADDRESS 240 Columbia St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cora	Middle Duft	Last Dailey
4. DATE OF DEATH	Month January	Day 11	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1879
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Edward Dufty		14. MOTHER'S MAIDEN NAME Emma Tralup	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Cuppett Nursing Home		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONVENTIVE HEART FAILURE DUE TO 4341			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4:21 p.m. 1959 January 1959 that I last saw the deceased alive on 4:21 p.m. 1959 , and that death occurred at 25 Cedar St. Oakland, Md. from the causes and on the date stated above ADDRESS (Street, city or town, state) 102/59			
ACTUAL SIGNATURE <i>E. I. Baumgartner, M. D.</i>		DATE SIGNED 102/59	
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/1959	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Mausoleum
22d. LOCATION (City, town, or county) Cumberland, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hayes. Cumbertant, Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 15 '59	24b. REGISTRAR'S SIGNATURE <i>John J. Hayes.</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06648

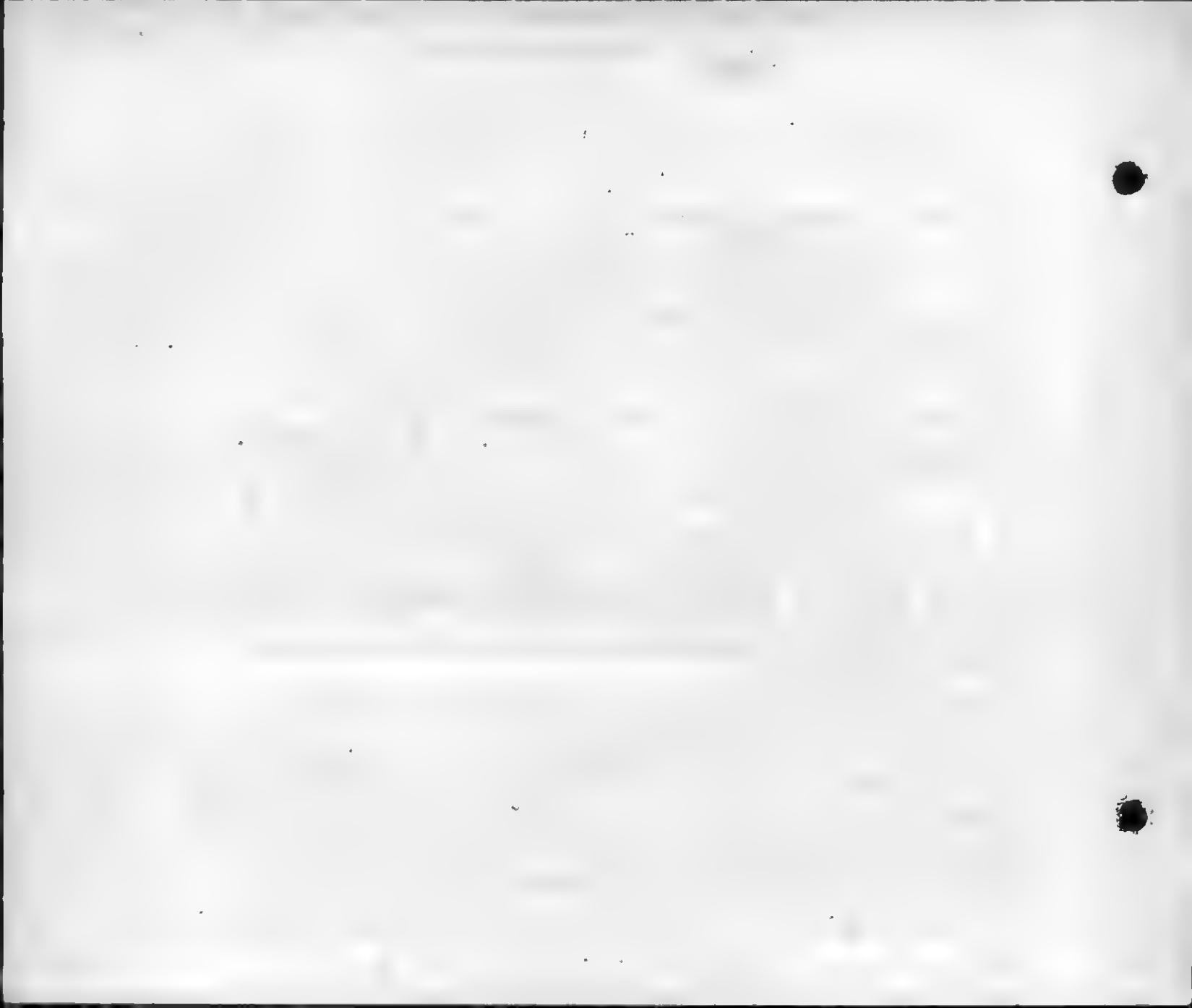
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		c. LENGTH OF STAY IN 1b 46 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin	
3. NAME OF DECEASED (Type or print) First: Rebecca Middle: Jane Last: DeWitt		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) near Sang Run, Maryland	
13. FATHER'S NAME Abraham Thomas		14. MOTHER'S MAIDEN NAME Sarah Teets	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Evelyn P. DeWitt, Crellin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0		INTERVAL BETWEEN ONSET AND DEATH Type	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		1/12.	
DUE TO MASSIVE PERITIC ULCER			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 1955 to <u>January</u> , 1957, that I last saw the deceased alive on <u>January 20</u> , 1959, and that death occurred at <u>1:50 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. IRVING BAUMGARTNER</u> M.D. <u>25608a 57</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1/31/59</u>	
PHYSICIAN'S NAME (Type) E. IRVING BAUMGARTNER		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb. 2, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Hoyes Cemetery		22d. LOCATION (City, town, or county) Hoyes, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. Watson</u>		24a. REC'D BY REGISTRAR FEB 2 '59 DATE	
ADDRESS Terra Alta, W. Va.		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Nease</u>	
Md. F.D. License No. A 6834			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

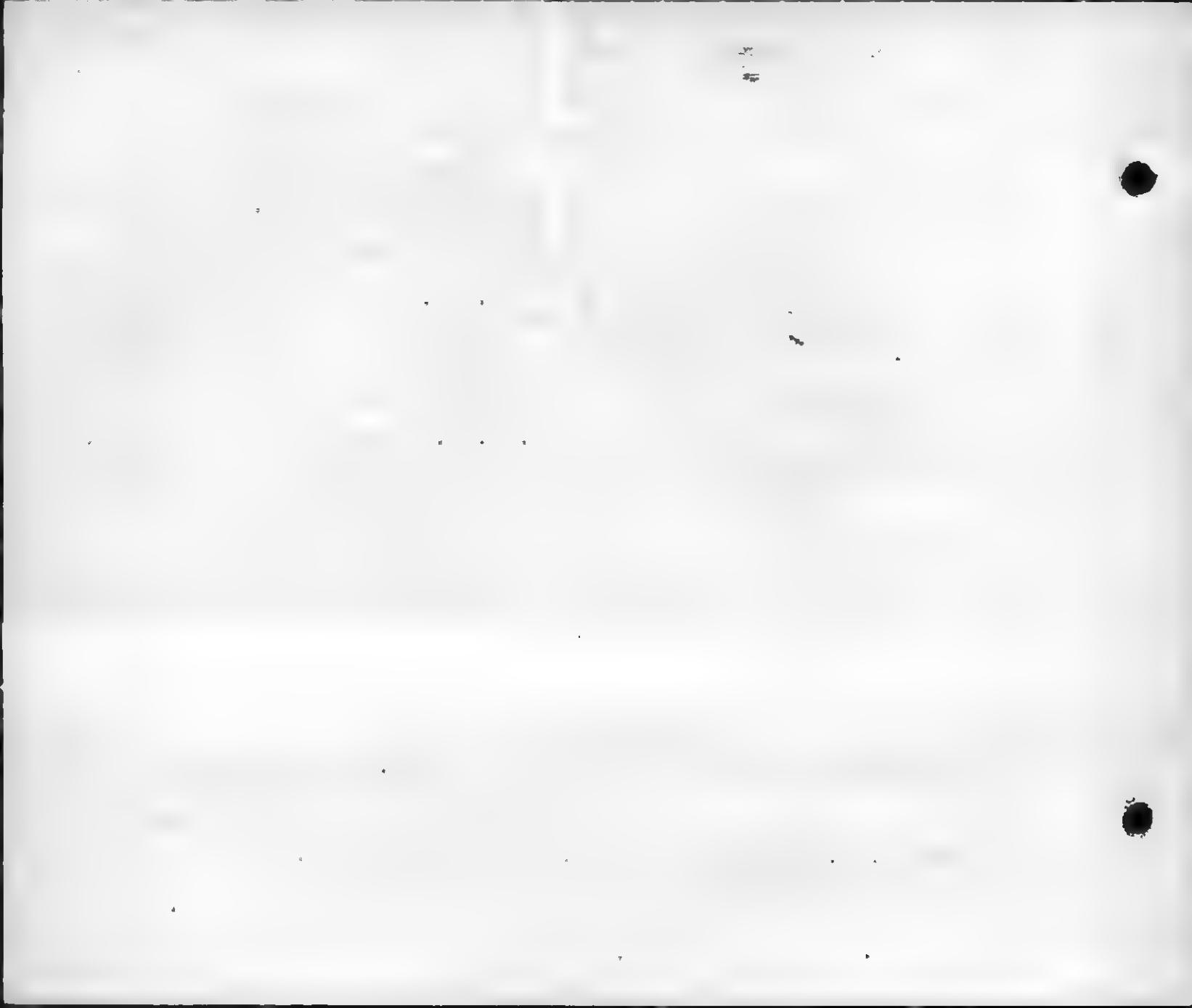
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4
 may be retained by the hospital or attending physician.
 ■ FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 657 CERTIFICATE OF DEATH 00649
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 3 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		d. STREET ADDRESS 134 Frederick St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Isabelle	Middle Everstine	4. DATE OF DEATH January 30, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1882
9. AGE (In years from birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David McCormick		14. MOTHER'S MAIDEN NAME Amelia Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. --	17. INFORMANT Mrs. G. C. Slaven	Address Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sorex		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic Bronchitis</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b). DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 1959, to <u>Jan 30</u> , 1959, that I last saw the deceased alive on <u>Jan 29</u> , 1959, and that death occurred at <u>Cumberland</u> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>134 Frederick St., Cumberland, Md.</u> DATE SIGNED <u>1/30/59</u>			
ACTUAL SIGNATURE <u>Dr. Baumgartner</u>		PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE <u>Feb 2 59</u>		24b. REGISTRAR'S SIGNATURE <u>E. Kean</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

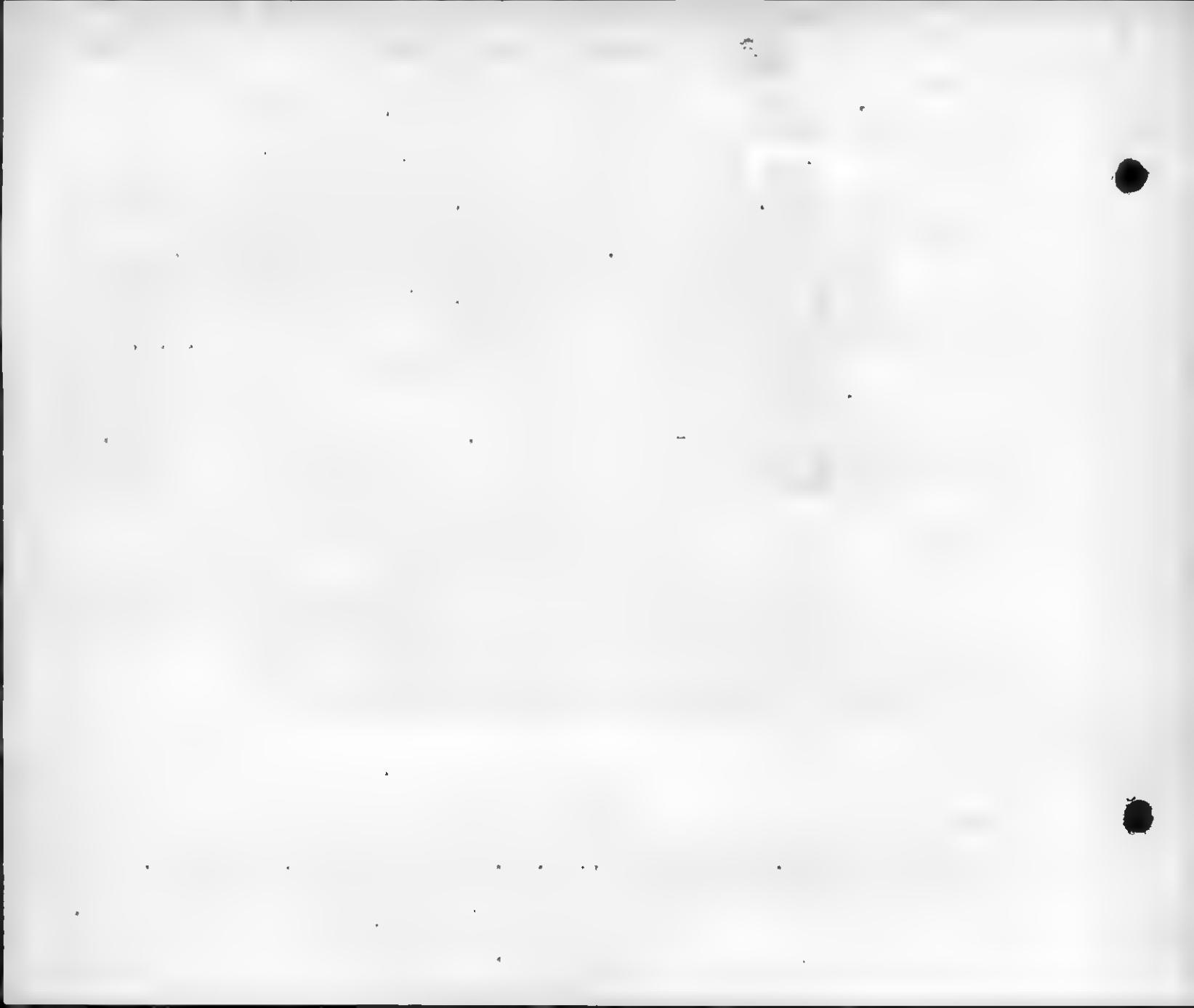
658

CERTIFICATE OF DEATH

Reg. Dist. No.

00650

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS 2 Mi. West Friendsville	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William	First	Middle J.	Last Frantz
4. DATE OF DEATH January 22,	Month January	Day 22	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1874
9. AGE (In years and birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. KIND OF BUSINESS OR INDUSTRY Own Farm	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Wesley J. Frantz	14. MOTHER'S MAIDEN NAME Susan Ross	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	
16. SOCIAL SECURITY NO. - - -	17. INFORMANT Merle D. Frantz	Address Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>J. Frantz</u>			
442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Anterior scoliosis</u> (c) <u>Chronic - Renal disease</u> 2 weeks			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1/1/58</u> to <u>1-21-1958</u> that I last saw the deceased alive on <u>1-19-59</u> , and that death occurred at <u>4:30A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		ADDRESS (Street, city or town, state) <u>58 2nd St. Oakland, Md.</u> DATE SIGNED <u>1-23-59</u>	
PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D.		Oakland, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/1959	22c. NAME OF CEMETERY OR CREMATORIUM Blooming Rose Cemetery near Friendsville, Md.
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE JAN 26 '59	
23. FUNERAL DIRECTOR'S SIGNATURE <u>He Leighton</u>		24b. REGISTRAR'S SIGNATURE <u>C. Smith, Jr.</u>	
ADDRESS Oakland, Md.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

659 CERTIFICATE OF DEATH

Reg. Dist. No. **00651**

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Gormania, W. Va.		b. COUNTY Garrett	
c. LENGTH OF STAY IN lb 70 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, P.O. Gormania, W. Va.	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Table Rock - Fairview Road		d. STREET ADDRESS Table Rock - Fairview Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle William	Last Gordon
4. DATE OF DEATH	January	Month	Day 13, 1959
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1873
9. AGE (In years to nearest birthday) 85 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired track worker, W. Md. R.R.Co.	11. KIND OF BUSINESS OR INDUSTRY Virginia.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Alexander Gordon	14. MOTHER'S MAIDEN NAME Mary Baker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) NO	16. SOCIAL SECURITY NO --	17. INFORMANT Mrs. Dora Gorden, R. D. Gormania, W. Va.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Bright's disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eglon, W. Va.
20f. (City or town) Eglon, W. Va.		(County) Garrett County (State) Maryland	
21. I certify that I attended the deceased from Jan. 12, 1959 to Jan. 13, 1959 , that I last saw the deceased alive on Jan. 13, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE N. F. Sabbagh		ADDRESS (Street, city or town, state) Eglon, W. Va.	
PHYSICIAN'S NAME (Type) N. F. Sabbagh, M. D.		DATE SIGNED 1/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/1959	22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery	22d. LOCATION (City, town, or county) Garrett County, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Reighton		24a. ADDRESS Oakland, Md.	24b. REC'D. BY REGISTRAR JAN 17 1959
		24c. DATE 1/15/59	24d. REGISTRAR'S SIGNATURE In 12 mth.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and in any event within 7 hours after death, the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

660

CERTIFICATE OF DEATH

Reg. Dist. No.

00652

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Oakland		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Zanie	Middle MAUDE	Last Kelso
4. DATE OF DEATH	Month January	Day 16	Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1884
9. AGE (In years last birthday) 75 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME Lucian Glover	14. MOTHER'S MAIDEN NAME Amy Snopps		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. -----	17. INFORMANT W.H. Kelso	Address Accident, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteric Dilatation			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) Robert H. Leighton, M.D., 77 Park St. Oakland, Md.	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 1957, to <u>January 16, 1959</u> , that I last saw the deceased alive on <u>January 16, 1959</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Robert H. Leighton, M.D., 77 Park St. Oakland, Md.			
ACTUAL SIGNATURE <i>Robert H. Leighton</i>		DATE SIGNED 17 Jan 59	
PHYSICIAN'S NAME (Type) Dr. Herbert Leighton, M.D.		22d. LOCATION (City, town, or county) (State)	
22e. BURIAL CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 1/19/1959	
22g. NAME OF CEMETERY OR CREMATORIUM St. Paul's Lutheran Cemetery, Accident, Md.		22h. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb Leighton</i>		24a. REC'D BY REGISTRAR DATE JAN 20 1959	
ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE W. S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

661

CERTIFICATE OF DEATH

Reg. Dist. No.

00653

<p>1. PLACE OF DEATH a. COUNTY Garrett</p> <p>MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland</p> <p>c. LENGTH OF STAY IN lb 1 month</p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home</p>				<p>2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland</p> <p>b. COUNTY Garrett</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville</p> <p>d. STREET ADDRESS ---</p>			
<p>3. NAME OF DECEASED (Type or print) Frederick</p> <p>First Lawson</p> <p>Middle Lowdermilk</p>				<p>4. DATE OF DEATH January 27, 1959</p> <p>Month Jan</p> <p>Day 27</p> <p>Year 1959</p>			
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH July 15, 1894</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Sawyer</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Saw Mills</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Walter Lowdermilk</p>				<p>14. MOTHER'S MAIDEN NAME Rebecca Stuck</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No</p>				<p>16. SOCIAL SECURITY NO. (If yes, give war or date of service)</p>			
<p>17. INFORMANT Mrs. Frederick Lowdermilk</p>				<p>Address Friendsville,</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X</p> <p>DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)</p> <p>DUE TO (c)</p>				<p><i>Carcinoma of lung. RT c metastasis</i></p> <p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>				<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</p>					
<p>20c. TIME OF INJURY Month Jan Hour 19 p. m.</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) Oakland, Md.</p>	
<p>21. I certify that I attended the deceased from Jan 26, 1957 to Jan 27, 1957, that I last saw the deceased alive on 26 Jan, 1957, and that death occurred at 11:30 P.M. from the causes and on the date stated above.</p>				<p>ADDRESS (Street, city or town, state) Oakland, Md.</p>			
<p>ACTUAL SIGNATURE <i>A. E. Mance</i></p>				<p>DATE SIGNED <i>1959</i></p>			
<p>PHYSICIAN'S NAME (Type) A. E. Mance, M. D.</p>				<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>			
<p>22b. DATE THEREOF 1/30/1959</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL Addison Cemetery</p>		<p>22d. LOCATION (City, town, or county) Addison, Penna.</p>			
<p>23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i></p>				<p>ADDRESS Oakland, Md.</p>		<p>24a. REC'D BY REGISTRAR Feb 2 1959</p>	
<p>24b. REGISTRAR'S SIGNATURE <i>John S. Price</i></p>							

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely signed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

100654

662 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY **Garrett**

MARYLAND

CITY (If outside corporate limits, write RURAL
OR end give nearest town)LENGTH OF STAY
(in this place)TOWN **Rural Friendsville**HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland**COUNTY **Garrett**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Rural Friendsville**STREET
ADDRESS
(If rural give location)3. NAME OF
DECEASED
(Type or Print)**George Mates**

(Last)

4. DATE (Month) (Day) (Year)
Jan 13 19595. SEX **Male**6. COLOR OR
RACE **White**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) **Married**8. DATE OF BIRTH
May 28, 18929. AGE last birthday
66 yrs.IF UNDER 1 YEAR
Months **0** Days **0** Hours **0** Min. **0**10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) **Blacksmith**10b. KIND OF BUSINESS
OR INDUSTRY **General**11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF WHAT
COUNTRY?**United States**

13. FATHER'S NAME

George Mates

14. MOTHER'S MAIDEN NAME

Mary Not Known15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) **Yes** (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS

Virgie Mates Friendsville, MdINTERVAL BETWEEN
ONSET AND DEATH

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE

(A)

Cardio Respiratory Failure

ANTECEDENT CAUSE(S) DUE TO

(B)

EXTREME Physical DeteriorationDISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

CARCINOMA of to base of the TongueII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**NONE**

20. AUTOPSY?

YES NO

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov 13, 1958**, to **Jan 13, 1959**, that I last saw the deceased
alive on **Jan 13, 1959**, and that death occurred at **11:30 AM**, from the causes and on the date stated above.

ADDRESS (Street, city, town, state)

DATE SIGNED

Pedro Rivera M.D. FRIENDSVILLE MD

1/16/59

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

Jan 16, 59

Blooming

Rose

Friendsville

Md.

REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE **JAN 19 59**

ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00655

Reg. Dist. No.

663

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore County, Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Baltimore, Maryland		Baltimore, Maryland	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
1 month		1221 - 21st & 22nd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Towson Hospital			
3. NAME OF DECEASED (Type or print)		First	Middle
T. J. K. Feaster		T. J.	K. Feaster
4. DATE OF DEATH		Month	Day
JULY 21 1959		JULY	21
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 6, 1915
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
113 yrs.		0 months	0 hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Librarian		Beachy Lbr. Co., Towson, Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Towson, Md.		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Feaster		Ida Wilhel.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		211-27-2218	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Subarachnoid hemorrhage, diffuse, acute	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Ruptured aneurysm, Circle of Willis	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 1-18-59	
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D. (Acting)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF	
Burial		1/21/59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State)	
Baltimore, Maryland		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE JAN 22 '59	
Bob Newman		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

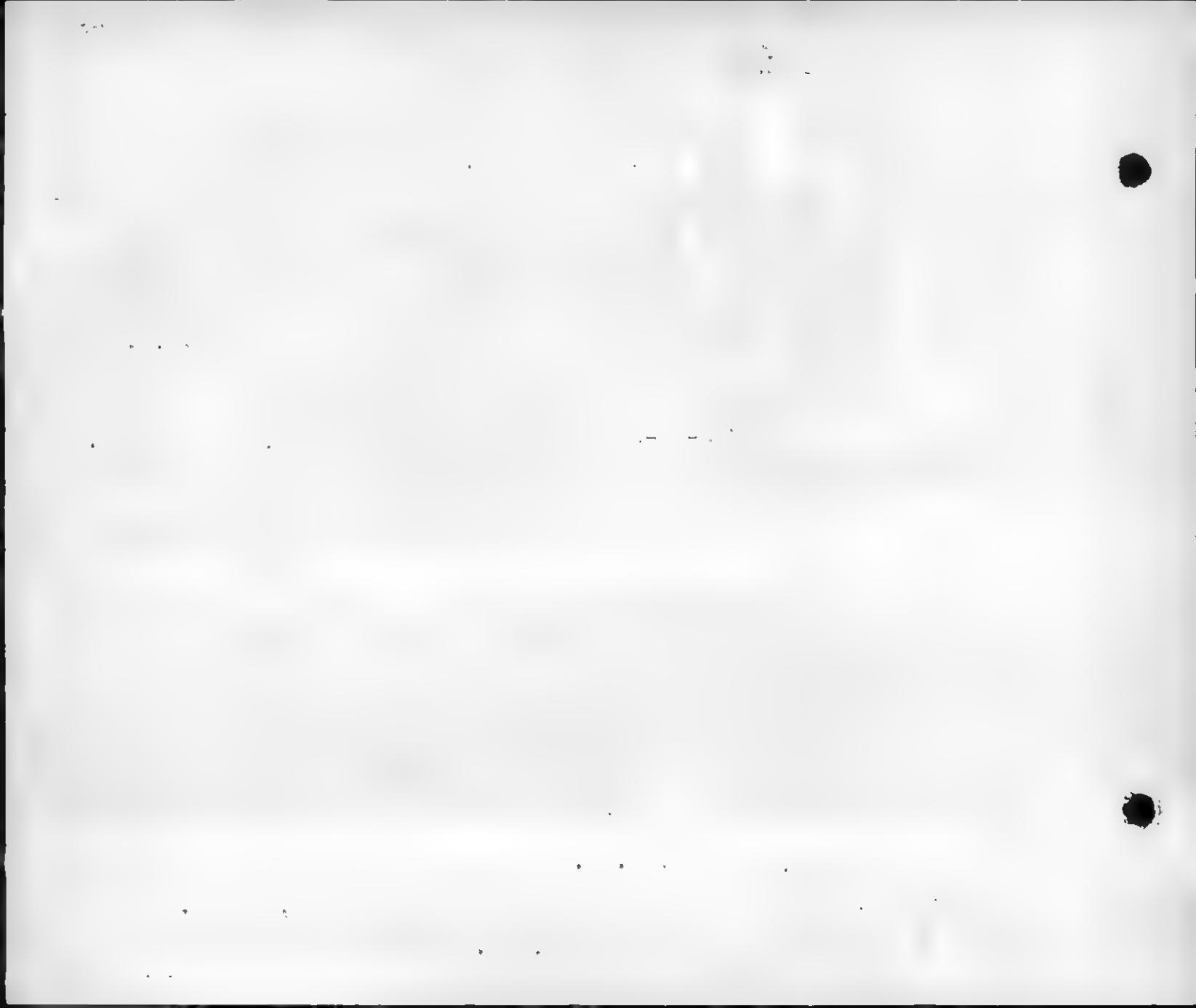
664

CERTIFICATE OF DEATH

00656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		b. COUNTY GARRETT	
c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X MT. LAKE PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHAUNCEY	Middle LAYMAN	Last MILLER
4. DATE OF DEATH	Month JANUARY	Day 7	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/82
9. AGE (in years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. FATHER'S NAME AWASTAH MILLER	14. MOTHER'S MAIDEN NAME ELLIE RODEHEAVER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no	16. SOCIAL SECURITY NO 715-01-9064	17. INFORMANT MARGARET SOLIARS	Address MT. LAKE PARK, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b). DUE TO (c). Chronic Passive Congestion Degenerative Cardio-Vascular Disease 2 years INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 1957, to January , 1959, that I last saw the deceased alive on January 7, 1959 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Herbert F. Leighton ADDRESS (Street, city or town, state) M.D. 77 Oak Street, Oakland, Md. 7 Jan 59 DATE SIGNED 7 Jan 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/9/1959	22c. NAME OF CEMETERY OR CREMATORIUM Addison Cemetery	22d. LOCATION (City, town, or county) (State) Addison, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JAN 9 '59	24b. REGISTRAR'S SIGNATURE C. L. S. - 1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 4 days, 4 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS N. Third Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Reaford	Middle John	Last Purbaugh
4. DATE OF DEATH	Month January	Day 5	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1928
9. AGE (In years last birthday) 30 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Auto supply store	
10c. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reaford B. Purbaugh		14. MOTHER'S MAIDEN NAME Ann Irene Lohr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO 212-24-1680	17. INFORMANT Mrs. Reaford J. Purbaugh, Oakland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia, Acute</i>		INTERVAL BETWEEN ONSET AND DEATH 5 days	
1/18 X	DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	5 mos.	
(b) <i>Generalized metastatic carcinoma</i>			
(c) <i>Primary site testis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemia marked</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 19 59</i> to <i>Jan 4 1959</i> , that I last saw the deceased alive on <i>Dec. 4 1959</i> , and that death occurred at <i>2:45 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>58 2nd St. Oakland, Md.</i>			
DATE SIGNED <i>Jan 5 1959</i>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>			
PHYSICIAN'S NAME (Type) Dr. James H. Feaster, Jr.		Oakland, Md.	
22a. BURIAL, CREMATION, BURIAL <input type="checkbox"/> Cremation <input type="checkbox"/>	22b. DATE THEREOF 1/7/1959	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery	22d. LOCATION (City, town, or county) Oakland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Keightley</i>		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR • DATE JAN 9 '59
			24b. REGISTRAR'S SIGNATURE <i>C. L. S. Head</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00658

Reg. Dist. No.

665

1. PLACE OF DEATH
a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oakland

c. LENGTH OF STAY IN 1b

1 week

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Garrett Co. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Garrett

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Friendsville

d. STREET ADDRESS

Rural

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
January

Day
24
Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
at birthday)

IF UNDER 1 YEAR
Months Days Hours Min

Male

White

WIDOWED

DIVORCED

May 15, 1885

73 yrs

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Timber Ind.

Hazelton, W. Va.

America

13. FATHER'S NAME

Samuel J. Sisler

14. MOTHER'S MAIDEN NAME

Mahala Rodeheaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or date of service)

No

No

16. SOCIAL SECURITY NO.

214-32-3535

17. INFORMANT

Chauncey Sisler

Address

Friendsville, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumia

INTERVAL BETWEEN
ONSET AND DEATH
3 days

160X

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

DUE TO

(b)

DUE TO

(c)

Diabetes Mellitus

Pituitary

10 years

10 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.

20d. INJURY OCCURRED
While at work Nat while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 1, 1959 to 24 Jan 1959 that I last saw the deceased
alive on 24 Jan 1959, and that death occurred at 6:10 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Andrew E. Mance, M. D.

Oakland, Maryland

PHYSICIAN'S
NAME (Type)

Andrew E. Mance, M. D.,

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

1-26-59

22c. NAME OF CEMETERY OR CREMATORIUM

Blooming Rose Ceme.

22d. LOCATION (City, town, or county)
(State)

Friendsville, Md.

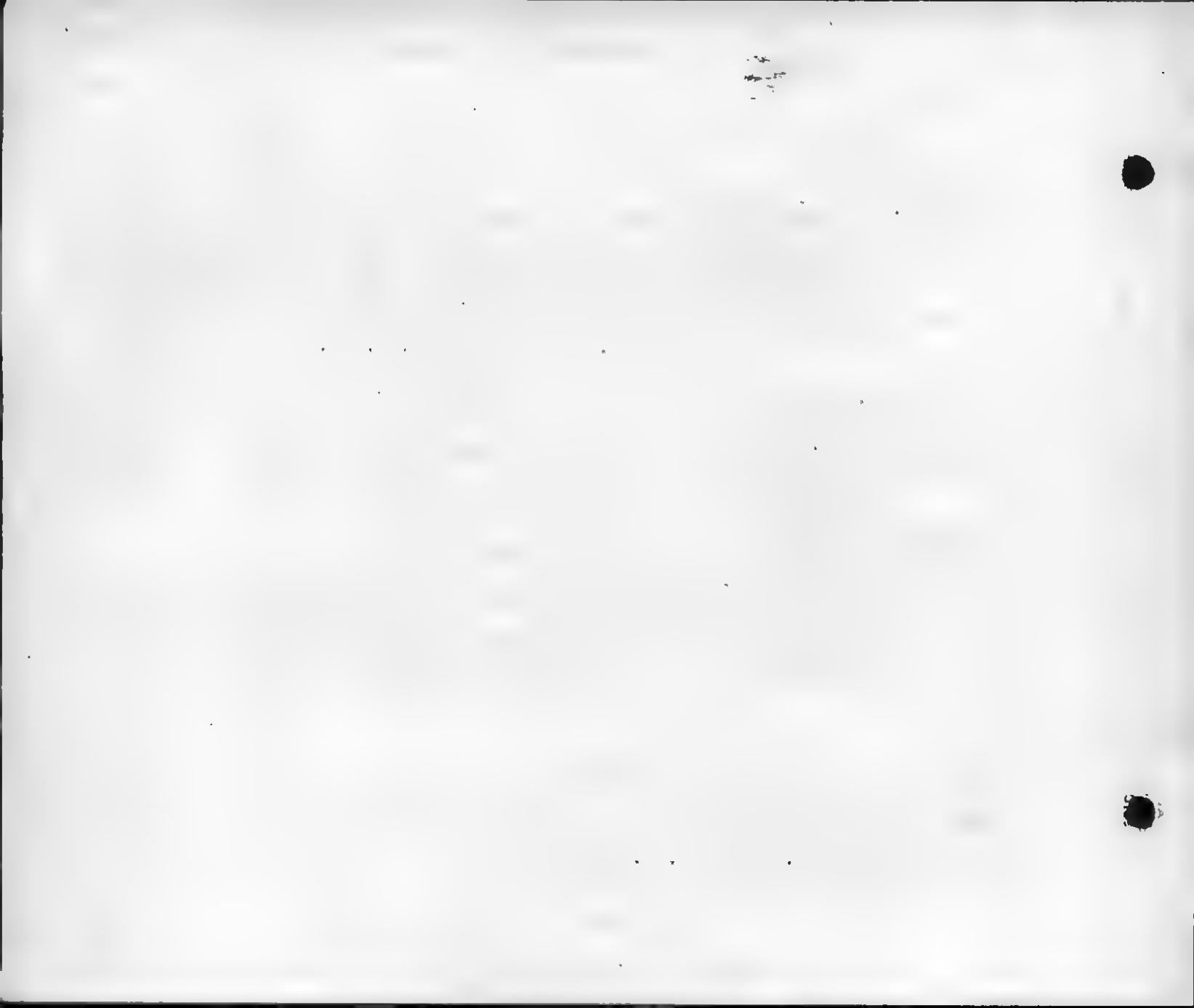
23. FUNERAL DIRECTOR'S SIGNATURE

W. H. Rodahaver, Minkleyburg, Pa.

ADDRESS

24a. REC'D BY REGISTRAR
DATE

24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be held with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death).

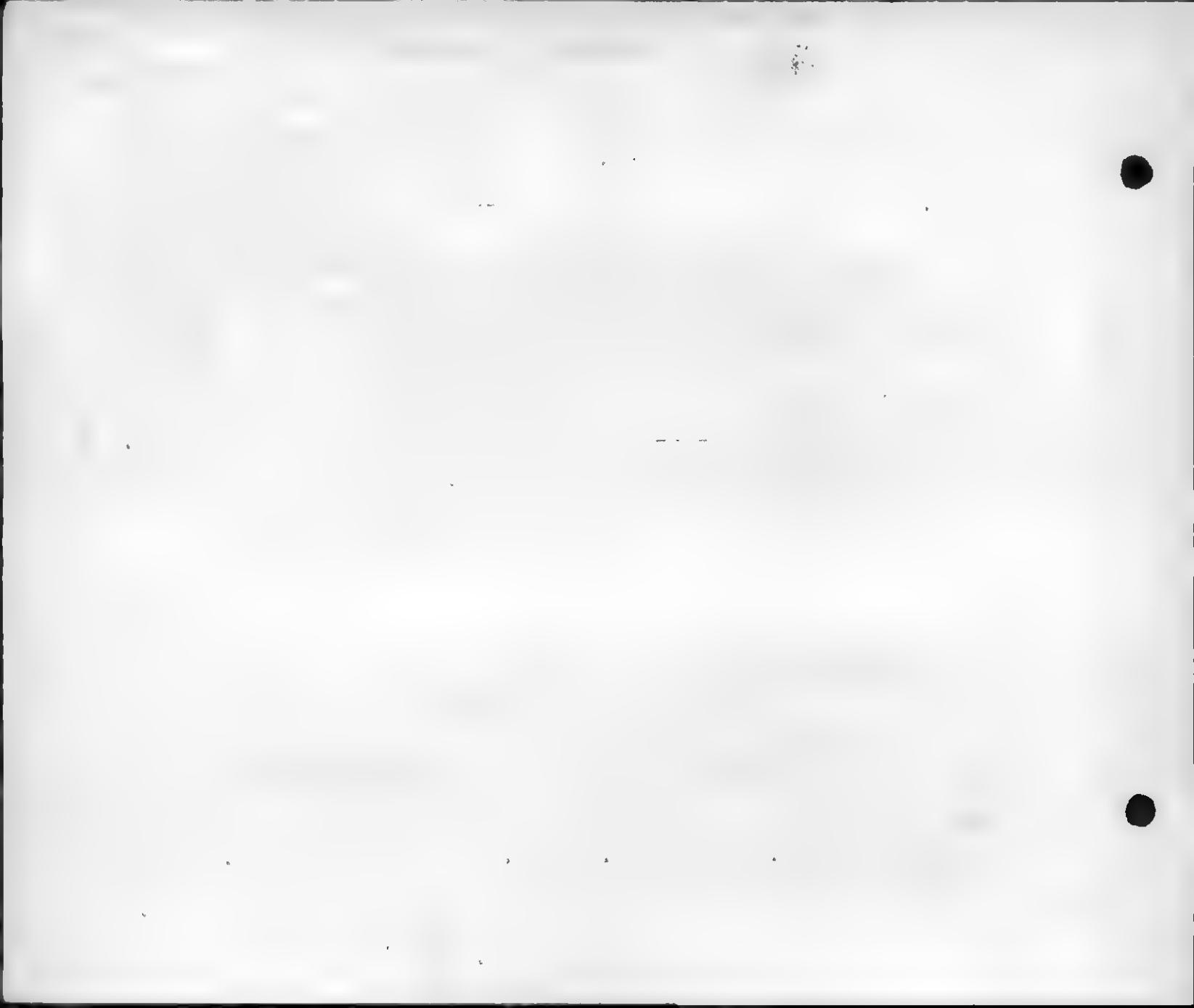
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00659**

667

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN lb 86 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		d. STREET ADDRESS ---			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 yrs. Weeks Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First William	Middle Jefferson	Last Sowers	4. DATE OF DEATH	Month January	Day 23,	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1872	9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Laborer for self & Others		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John A. Sowers		14. MOTHER'S MAIDEN NAME Mary Margaret Hilberg							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Allen Paugh		Address Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		DUE TO Pneumonia, Acute		INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. ---		(b) Carcinoma of lung, Primary 6 mos							
(c) C. m. d. d. s.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58 21st Oakland, Md.		20f. (City or town) 58 21st Oakland, Md.		(County) 58 21st Oakland, Md.	(State) 58 21st Oakland, Md.
21. I certify that I attended the deceased from 1-2 , 19 57 , to 1-21 , 19 59 , that I last saw the deceased alive on 19-21 , 19 59 , and that death occurred at 6:15 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 58 21st Oakland, Md.		DATE SIGNED 1-23-59			
ACTUAL SIGNATURE <i>James H. Feaster Jr., M. D.</i>									
PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/1959		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland, Maryland.		(State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DAJ 20 '59		24b. REGISTRAR'S SIGNATURE <i>Cathy L. Knue</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00660

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
Garrett		Bittinger		Life		d. STREET ADDRESS			
MARYLAND						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		4. DATE OF DEATH	Month	Day	Year
George		William		Stark		January	20	19	59
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 65 yrs.	
Male		White				Oct. 24, 1893		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Farmer		Own Farm		Bittinger, Md.		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				Address			
Peter G. Stark		Lydia Slaubaugh							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 771 NITES	
(If yes, give war or dates of service)		220-26-9374		Mrs. Sara Stark, Bittinger, Md.		Hanging By Neck			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		b)		DUE TO		c)	
974X									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE		James H. Feaster, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1-20-59	
EXAMINER'S NAME (Type)		JAMES H. FEASTER, M.D. (Acting)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial		1/23/59		Bittinger		Bittinger, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Ron J. Newman		Grantsville, Md.							
VS. A1SME(S) SM 9/55		DATE		JAN 22 '59		S. J. Feaster, M.D.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

669 CERTIFICATE OF DEATH

00661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Robert	Middle L.	Last Wolfe
4. DATE OF DEATH	Month January	Day 8,	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/25/1889
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wolfe, John L.		14. MOTHER'S MAIDEN NAME Smith, Julia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes No, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carter's Anorectum ruptured 8 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 _____, to January 8, 1959, that I last saw the deceased alive on January 8, 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. E. Mance</i> ADDRESS (Street, city or town, state) <i>Oakland, Maryland</i> DATE SIGNED <i>January 8, 1959</i>			
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) burial	
22b. DATE THEREOF 1/12/59		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery	
22d. LOCATION (City, town, or county) Oakland Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland Md.	
24a. REC'D BY REGISTRAR DATE <i>JAN 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kassel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

2025 RELEASE UNDER E.O. 14176 - DEPARTMENT OF DEFENSE - STATEMENT

CLASSIFIED BY: 2025